stipation. Comorbidities and drug utilization related to constipation were also assessed.
RESULTS: 9,301 patients met all inclusion criteria. The mean age was 39.74 years and 63.41% of the sample was female. The most commonly observed comorbidities were hypertension (16.3%), diabetes (7.5%), diverticulitis (7.4%) and irritable colon (5.9%). Approximately 8% of the sample received medications thought to have constipating effects in the 6-month period prior to their constipation diagnosis. Prescription laxative use was observed in approximately 3% of subjects after the constipation diagnosis. Average costs rose from $277 (SD = 1717) 6 months prior to the constipation diagnosis to $1031 (SD = 4402) during the month of the diagnosis. Similarly, average costs decreased from $890 (SD = 3852) in the month directly following the index date to $479 (SD = 3470) in the sixth month following the index date.
CONCLUSION: Costs associated with the diagnosis and treatment of constipation patients appear to be concentrated around the index visit. Early detection and resolution of constipation could result in significant cost savings for managed care organizations.

PGI3

DIFFERENTIAL COST OF USING NSAIDS IN A MEDICAID POPULATION

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OBJECTIVES: To estimate the differential cost of using non-steroidal anti-inflammatory drugs (NSAIDs) in a Medicaid population. NSAID use is associated with adverse gastrointestinal (GI) events such as GI distress, symptomatic ulcer, and anemia, which vary in severity and may require symptomatic treatment or hospitalization. The economic burden of these events is represented by the differential cost of treating NSAID-related toxicities.
METHODS: Treatment cost and adverse GI event rates were compared for two cohorts (NSAID and non-NSAID users) selected retrospectively from the South Carolina Medicaid population. To be included in the analysis, all subjects must have been at least 18 years old and continuously eligible for 12 months following an index event in 1995. For NSAID users, the index event was at least two NSAID prescriptions or a 60 day supply (n = 21,278). For non-NSAID users (comparator group), the index event was at least one prescription during 1995 (n = 152,072). Average cost per subject by type of service (physician, other ambulatory, inpatient hospital, outpatient hospital, emergency department, prescription drugs) was compared for the cohorts. Regression analysis was used to evaluate the effect of NSAID use on treatment cost, controlling for age, gender, prior exposure to NSAIDs, use of gastro-protective agents, and adverse GI events.
RESULTS: NSAID users had higher physician ($1885 vs. $1488), other ambulatory ($5785 vs. $5060), inpatient hospital ($5966 vs. $3326) and prescription drug ($1012 vs. $738) costs than the non-NSAID group. Regression analysis showed that NSAID use was a significant explanatory variable ($p < 0.0001$), as were age, gender, race, and adverse GI events.
CONCLUSIONS: NSAID use is associated with higher average treatment costs and is a significant predictor of modeled treatment costs after controlling for other effects. Substantial cost savings may be realized if NSAID-related GI toxicities and adverse events can be managed or avoided.

PGI4

COST OF ITALIAN DYSPEPTIC PATIENTS: A FEASIBILITY STUDY FROM THE DYSPEPSIA PROJECT

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The Dyspepsia Project is a General Practitioners' (GPs) project, aiming to establish an epidemiological database in order to describe and follow up dyspeptic patients in the Ravenna area.
OBJECTIVE: To investigate the feasibility of a cost of illness study on the dyspeptic patient in terms of healthcare resource use, and to produce an average cost per patient.
METHOD: Retrospective cost of illness analysis based on records of 106 dyspeptic patients followed by 10 GPs. This preliminary analysis has been performed in the perspective of Health System. Patients analyzed were enrolled between September and December 1999 and followed up at least for 6 months. Hospital admissions; GP, specialist and emergency room visits; instrumental and laboratory tests; drugs were analyzed; each cost variable was valued in Italian Liras 1999 (1800 ITL = 1 US$) using published regional or national tariffs and marked prices for drugs. Patients have been divided into Group A (37 = 35%) and Group B (69 = 65%), according to whether they underwent or not gastroscopy test.
RESULTS: The average cost per patient was ITL 1,121,654 in A Group and ITL 624,565 in B Group. Direct costs accounted for 76.5% of the total value in A Group and for 70.9% in B Group, while the remaining 23.5% in A Group and 29.1% in B Group was due to indirect costs (i.e., productivity losses). In Group A the major cost driver was drugs (40.8%) (13.6% was the share of antidyspeptic drugs) followed by tests (18.4%), visits (15.6%) and emergency room visits (1.7%); in B Group the major cost driver was drugs (38.6%) (10.1% was the share of antidyspeptic drugs) followed by visits (19.5%), tests (9.2%) and emergency room visits (3.6%).
CONCLUSIONS: Collection of cost data at General Practitioner's level is very effective as it allows a precise and appropriate analysis.